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ABSTRACT

Child Life Programs in hospital settings aim to involve children in activities and relationships appropriate to their needs. Child Life programming is an essential component of health care, as it promotes: (1) advocacy for children, families, and individuals; (2) the sharing of resources and knowledge; (3) cohesion in the health care team; and (4) the ability to cope effectively with stressful situations. It is cost efficient and results in good public relations. Child Life encompasses assessment and planning; the building of supportive relationships; preparation; health care play activities and other focused interactions; support during medical procedures; documentation; and interdisciplinary collaborations. This paper offers observations on Child Life Programs in Australia, England, Canada, and the United States that are drawn from experiences at the Royal Children's Hospital in Melbourne, Australia and visits to hospitals in the other countries. Topics addressed include the importance of play and the consequences of cultural tendencies to trivialize it; efforts to incorporate a Child Life approach at the Royal Children's Hospital; and differences in the development of policies, accreditation standards, and quality assurance guidelines in Canada, England, and Australia. The paper highlights the Child Life program at the Johns Hopkins Children's Center in the United States as an outstanding example of well-integrated care and education. The paper concludes by discussing the benefits of Child Life departments, including the reduction of post-hospital psychological upsets and the increased efficiency of allied health professionals. (AC)

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PLAY AND EDUCATION IN HOSPITAL

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Getting Your Act Together

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September, 1991

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Workshop for the Fifth Early Childhood Conference in Dunedin - New Zealand

Firstly, I would like to introduce myself. My name is Maree Matthews and I work at the Royal Children's Hospital, in Melbourne - Australia. I am the Chief Play Specialist, Head of Play and Education. I take great pleasure in speaking to you today on "Play and Education in the hospital setting." It is something that means a great deal to me both professionally and personally.

For the success of this workshop, it depends on you. I would like to commence by first asking you of your experience and impression of Play and Education in the Hospital setting.

Q. Who would like to share an experience or an impression they have of Play and Education?

I believe, to Play is to live, and to live is to learn. If we seek a definition on play it can mean many things to different people. **"A century or so ago the full importance of play was not appreciated and even for the children of the wealthier classes lit was frowned upon as frivolous, unnecessary and a manifestation of idleness". (Clarke, 1973, Pg. 2)**

To the untrained eye it can mean something that is frivolous or entertaining. According to the Dictionary of Psychology, **"Play is activity which is pursued for individual or group enjoyment without any ulterior motive." (1983, Chaplin, Pg. 392)**

I believe play is an integral part of a child's life. Garvey compiled a list of elements which characterise play. Briefly he said

- **Play is pleasurable and enjoyable**
- **Play has no extrinsic goals. It's motivations are intrinsic and serve no other objectives.**
- **Play is spontaneous and voluntary.**
- **Play involves some active engagement (1977, P. 65)**

Through this definition of Play, Garvey clarified the reasons for considering some activities as play, and excluded others that were similar.

If we refer to Virginia Axline's definition of Play Therapy, it **"is based upon the fact that play is the child's natural medium of self expression. Play Therapy may be directive in form - that is, the therapist may assume responsibility for guidance and interpretation, or it may be non-directive: the therapist may leave responsibility and direction to the child." (1989, Pg. 8)**

What does it mean to educate. According to the English Dictionary, it is **"to provide schooling for; teach mentally and morally; train, improve and develop (1989, Pg. 173).** If we refer to the dictionary of Psychology, educability, **"is the potentiality for learning, particularly for formal, scholastic learning." (Chaplin, 1983, Pg. 163)**

Where does that leave Play and Education in the Hospital setting?

Overhead 1: Getting your act together

"The basic principles of non-directive therapy seem to have far-reaching implications for educators. The people who are closely associated with the schools today, know that the primary need for the successful education of the children is sound mental health for all participants in the educational process." (Axline, 1989, Pg. 133)

At the Royal Children's Hospital in Melbourne, we have evidence of Play and Education in existence all around the hospital. We have a Department of Play and Education that consists of thirteen Play Specialists and one Music Therapist. We also have a school that has fourteen primary and two secondary teachers. Within the hospital we have six Pre-school Mothercraft Nurses and one Recreationalist. In total thirty-seven staff members within the Hospital catering for children's non-clinical needs.

Overhead 2 **Structure of Play and Educational facilities at the Royal Children's Hospital, Melbourne.**

Overhead 3 **Structure of overseas department**

On commencement at the hospital I was a Senior Play Specialist within the Department of Play and Occupational Therapy. I was concerned at the poor staff morale and above all the slap dash approach of servicing the non-clinical needs of children in the hospital. After reviewing the Play Department, I realised the staff had great concern about their future and what they were actually achieving. I discussed these issues at length with my superior the Chief Occupational Therapist. It soon became very evident, with all due respect to the Chief Occupational Therapist that we had very different philosophies and objectives. I wanted to support her in her role but found it difficult. I summarized the difference in our professions and service delivery. They included the following: Play and Education staff work with individuals as well as groups of children. The Occupational Therapists work on a referral basis only, we work with the child as part of the family unit. Our role also

encompasses public relations, education and facilitating advocacy from children and families in hospital.

Overall - it was time for change. I soon discovered that the Chief Executive Officer had wanted to implement the concept of "Child Life" in the early eighties, hence he would be receptive to this change.

According to Wilson, **"Child Life program aims to involve children in activities and personal relationships appropriate to their needs. it is not a program for a select group of children, it is a programme for <u>all</u> children. It is based soundly on child growth and development principles and on the special needs of hospital children and their families" (1985, Pg. 3)** Child Life encompasses - **"assessment/planning, building supportive relationships, preparation, health care play activities and other focused interactions, suppport during procedures, documentation and interdisciplinary collaboration (Gaynard et. al., 1990, Pg. 27)**

"In 1960, at the John Hopkins Hospital Children's Center, there was anticipation of a new Children's Centre and a changing concept of the role of play activities program, a new name was chosen - Child Life Program" (Wilson, 1988, Pg. 82)

The concept of Child Life was also adopted by the Association for the care of Children's Health to unify the services specifically offering Play Education and Recreation in Health Care Settings.

" Programmes in Canada and North America were also once identified with a selection of names. For example "Child Life, Children's Activities, Play Program, Play Therapy, Recreation, Therapeutic Play, Paediatric Play, Child Development, Activity Therapy and Child Life and Education". (Association for the Care of Children's Health, 1984, Pg. 1)

To enable children's and families needs to be met and maintained within Health Care settings, the Association for the Care of Children's health have established statements of Policy. To ensure these needs are addressed, it is imperative that they are included in accreditation guidelines. For further clarification on the concept of Child Life, they also released a Child Life Position statement. Canada has formalised their Child Life Services which are now recognised by the National Canadian Medical Association. The guidelines focus on Acute Care Standards which place standards on the following areas of the Child Life Service. Statement of purpose, goals and Objectives, Organisation and Directions, Policies and Procedures, Human and Physical Resources, Orientation, Staff Development and Continuing Education, Patient Care and Quality Assurance. In February 1991,the above was accepted as a draft. With further consultation, it is envisaged that it will be accepted and implemented.

In Australia the accreditation guidelines specifically for Play and Educational programmes are inadequate and are well overdue for reviewing. If we consider a preliminary survey being done by the Australian Association for Welfare of Children in Hospital, this is quite evident. 75% of Australian hoslpitals do not have Play or Recreation staff. It was interesting to note hospital Educational facilities were not recorded. The official survey is due to be released next year.

It is up to us as professionals in Play and Education, to promote a cohesive approach to programming in this area of specialty. Our role as Child Life Specialists entails **"promoting the development of programs which is based on a multidisciplinary emphasis and its focus on the psychological and social aspects of the care of hospitalized children" (Association for the Care of Children's Health, 1984, Pg. 1)**

"The integration of care and education varies from hospital to hospital. The John Hopkins Hospital children's Centre in United States of America, was the most outstanding programme I observed. It was evident that a lot of the time was spent ensuring integration took place. Staff were referred to as Child Life Teachers. They offered "opportunities or education as well as the traditional Child Life activities, such as play, group meals, caring for pets and plants, cooking activities, films, and the like." (Wilson, 1979, Pg. 82) Child Life operated within the Department of Paediatrics as an integral part of the overall services for children. There had been many changes in funding guidelines, by the state government, but the hospital managed to maintain service delivery. "Although the financial assistance had ceased from the state and the teacher certification requirements are no longer binding child life had chosen to continue offering the same quality education program." (Wilson 1979, Pg. 83) Through initiating the educational services within the Child Life concept, all children's and families needs were met. "On each unit there were two Child Life teachers, one trained in early childhood education, the other in elementary education." (Wilson, 1979, Pg. 84) With the combination of staff, resources and philosophy, the hospital programme is one of the most progressive and successful programmes in the United States of America. They have a staff establishment of twenty-four effective full-time,with one hundred and ninety Paediatric Beds.

"The curriculum for hospitalised patients is established with two purposes in mind:

1. to offer age-appropriate work that would be equivalent to what a child would have in his own school and
2. to maximise the learning potential about the environment in which the child is located - the hospital." (Wilson 1979, P 84).

In England, the Play Specialists worked separately from the teachers. Both were in separate departments, had very different training and there was no official resourcing or integration. Due to the differences in training and rigid funding bodies, there had been no attempt to integrate the services on a departmental level, or through service delivery. It was evident that there was a lot of animosity between roles and conditions of employment.

To ensure quality assurance and maintain appropriate service delivery, many of the Child Life Departments I visited were in the process of writing or had written a Quality Assurance document. They included the JACHO ten step process, which was to define responsibility, delineate scope of care, identify important aspects of care, establish indicators, establish thresholds for evaluation, collect and organise data, evaluate care, corrective action, assess effectiveness of actions and communicate findings "The monitoring and evaluation process is designed to help health care organisations effectively use their quality assurance resources by focusing on high-priority quality of care issues" (Joint commission, 1991, Pg. 218)

Quality Assurance in this specialty in Australia is at present addressed on an adhoc basis.

In England, the Play in Hospital Liaison committee presented a document on: ' Quality Management for children: Play in Hospital.' The National Association for the Welfare of Children in Hospitals and the Minister for Health, Virginia Bottomley, made significant contributions to the document. It offers a practical guideline for the development of hospital play programmes. The practical format provides a comprehensive orientation to play in hospital.

Without the accreditation guidelines to enforce certain standards for children and families in health care settings, it will be used merely as

a guide for health organisations with no jurisdiction to ensure quality assurance.

When children and the families enter hospitals, it is quite often in an emotionally vulnerable state. Professionals can assist by planning and ensuring quality of service delivery is maintained. With regard to the concept of Child Life or Play and Education,; the process is somewhat difficult. The real meaning of the work done by Child Life professionals is often marred by the frivolous nature conjured up by the term play. "The right to play is truly a basic night for each child, whatever the social or economic situation may be. Indeed, the fostering of play is clearly part of preventative medicine"(Peterson, 1989, Pg. 22).

I believe the inclusion of Child Life programming in a health care setting is an essential component as it promotes advocacy for children and families as individuals, sharing of resources and knowledge, overall cohesion in the health care team, development of abilities to cope effectively with stressful situations , cost efficient, and excellent public relations. We are one of the few departments that cater for all children's non-clinical needs and interests. "Child Life programs strive to promote the optimum development of children and adolescents in health care settings. " (Gaynard 1990, Pg. 1). It is vital that Child Life programmes exist to normalise the child and families experiences and to minimise potential psychological trauma. "A child who has been adequately prepared for the induction of anaesthesia and is cognizant of its benefits, as well as anticipated unpleasantness such as a funny smell or the prick of a needle, will likely face the event with a

greater sense of colour and control than the child who must rely on inner fantasies as a source of explanations. (Thompson and Stanford, 1981, Pg. 221)

If we were to prepare a cost/benefit analysis, on the surface, the results would differ greatly from other departments. Child Life departments don't generate income like others. We demonstrate cost efficiency by reducing post-hospital psychological upset, time spent in preparing and briefing children and families about the hospital and medical procedures. We spend time with children and families that nursing and other allied health professionals are unable to do, hence they are more efficient in their day to day work. We promote the hospital by continually presenting a passive profile in caring for children and families non-clinical needs. The amount of money contributed to the promotion of a fully comprehensive Child Life programme at the Royal Children's Hospital has been minimal. All the funding for Early Childhood teachers comes from Community Services, Victoria. I believe, if a hospital wants to promote the non-clinical needs of children and families and to introduce the Child Life Concept, then we all have to work towards a cohesive approach. I would like to conclude this session with the following quote and comments.

"When I arrived at the nursing station, I had an immediate feeling - and it was very strong - that there was something profoundly different in that environment from what I had experienced during my six week clerkship at Babies and Children's uptown. I didn't know what in the world it was, but it was one of those gut feelings where something is really strange and different. I introduced myself to the head nurse and explained that I was a medical student starting a clerkship, and she asked me if she could help me with anything. I said, "Yes, I have a question. I've had this strange feeling since I have been standing here: it's extremely quiet - I don't hear any children crying. Could you tell me how that could be?" She looked at me and got a twinkle in her eye and

pointed into the ward. She said "Do you see that little lady down there at the end with those two college students?" (Rothenberg, 1982, Pg.121). Do you know who that little lady was?

Professor Michael Rothenberg was accurate in his observation at the two Paediatric settings. He cared enough to question and discovered what we know today as the concept of 'Child Life'.

I hope I have provided some information for you to question and evaluate, the Play, Education and Recreation programmes that you are involved in or perhaps what programmes should be in practice in your health care setting.

Last overhead

Questions

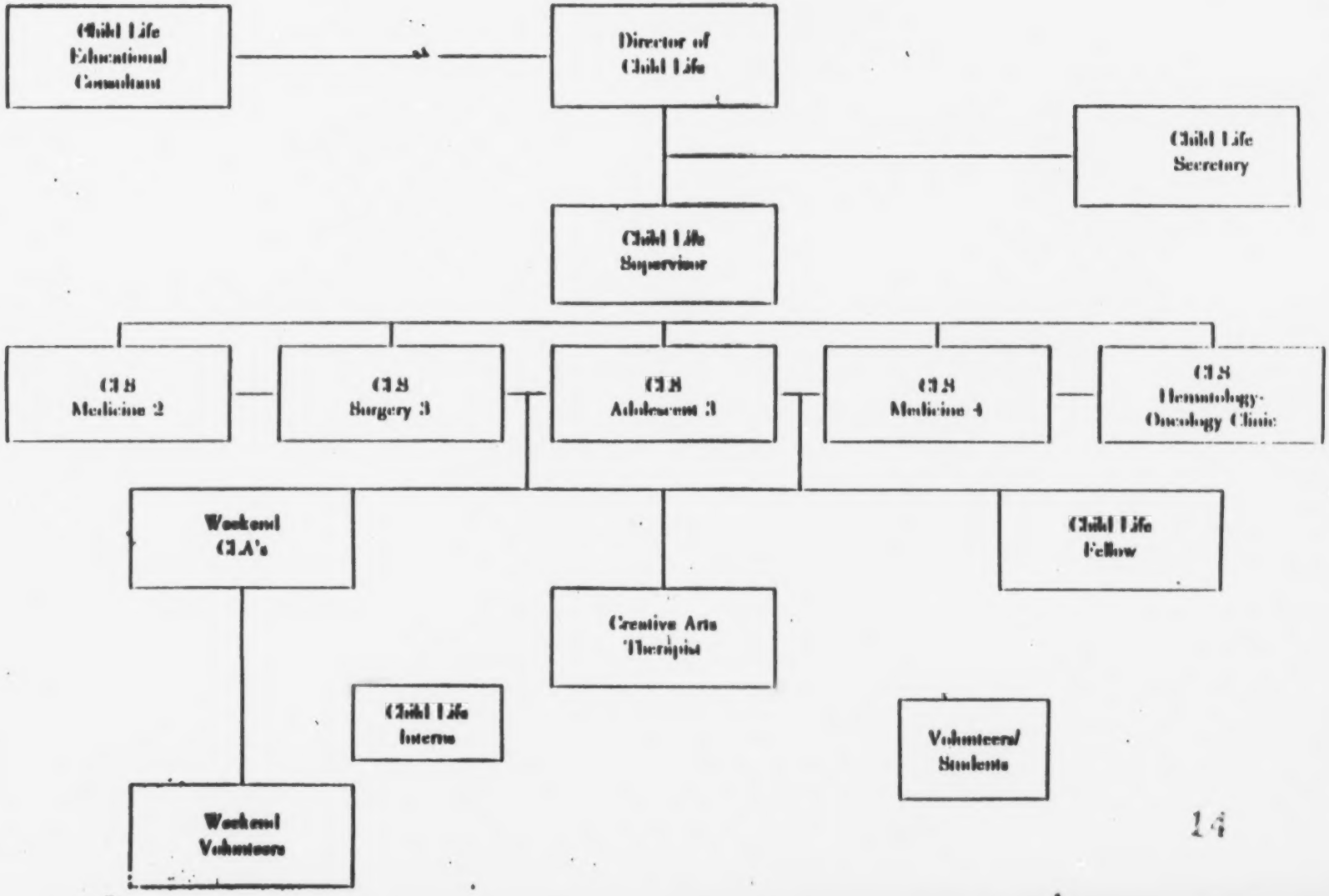
Discussions

Slides from R.C.H.

OVERSEAS MODEL

Schneider Children's Hospital
of Long Island Jewish Medical Center

Child Life Program Organizational Structure



MELBOURNE

ROYAL CHILDREN'S HOSPITAL

DEPARTMENT OF PLAY AND EDUCATION

CHIEF PLAY SPECIALIST
Referrals from I.C.U. Neonates, Emergency, Outpatient Clinics, Psych. Ward

DEPUTY CHIEF PLAY SPECIALIST (Senior)
.3 Plastic Surgery
.2 Day Centre

In house Television Co-ordinator

Secretary .5

Play Specialist
.5 Burns/Diabetics

Play Specialist
.7 Cardiac Surgery
.3 Referral to the Wards

Play Specialist
.7 Oncology/Haematology
.3 Oncology/Haematology O.P. Clinics

Play/Dance Specialist
..5 referral work to
2 North - Psych. Unit

Play Specialist
.5 General Surgical

Play Specialist
.7 General Surgical
.3 Theatre

Play Specialist
.5 General Medical

Play Specialist
.5 Orthopaedic Surgery

Play Specialist
.5 General Medical

Play Specialist
.3 Plastic Surgery

Play Specialist
.5 Neurosurgery

Play Specialist
.7 Gastroenterology/ Thoracic
.3 Acute Gastric Respir.

Music Therapist
Referral Basis

AS PROFFESSIONALS

WE CAN DO IT

CAN'T WE?

REF-1-92

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